

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10370

10380

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY HOWARD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLIOTT CITY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLIOTT CITY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHAFFERS NURSING HOME		d. STREET ADDRESS ROGERS AVE PT 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First IRIS	Middle WOODWARD	Last BEDISH	4. DATE OF DEATH Month OCT. 12, 1956	Year 19		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 26, 1901	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) LOUDON, KENTUCKY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN F WOODWARD		14. MOTHER'S MAIDEN NAME MATTIE LOVELACE		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertension (c)	
						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-11 , 19 56 , to 10-12 , 19 56 , that I last saw the deceased alive on 10-17-56 , 19 56 , and that death occurred at 4:45 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Peter V Thorpe		M.D. COLUMBIA RD		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) PETER V THORPE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-16-56	22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. CHICAGO, ELLICOTT CITY, MD.		ADDRESS		24a. REC'D BY REGISTRAR OCT 16 1956	24b. REGISTRAR'S SIGNATURE J. B. Daugherty		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 19 —

BUREAU Y. S.

OCT 16 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10381

CERTIFICATE OF DEATH

10371 91

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refused by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, ~~entombment~~, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 7/11

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Old Annapolis Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Annapolis Road				d. STREET ADDRESS Old Annapolis Road		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HARRY THOMAS GERWIG		First	Middle	Last	4. DATE OF DEATH October 12, 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. B. DATE OF BIRTH 7-15-1892	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Gerwig		14. MOTHER'S MAIDEN NAME Ardella Grimes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Daisy Gerwig, Ellicott City, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO Coronary atherosclerosis (c)						years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral thrombosis & left hemiparesis (11 mo.)						
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Ellicott City, Md.	(County)	(State)		
21. I certify that I attended the deceased from Oct. 8, 1955, to Oct. 11, 1956, that I last saw the deceased alive on Sept. 19, 1956, and that death occurred at 10 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED Donald E. Fisher, M.D. Oct. 12, 1956								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-15-56	22c. NAME OF CEMETERY OR CREMATORIAL St. Johns	22d. LOCATION (City, town, or county) Ellicott City, Md	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS	24a. REC'D BY REGISTRAR DATE Oct. 16, 1956	24b. REGISTRAR'S SIGNATURE J. E. Leigher				

U. S. BUREAU

OCT 16 1956

RECEIVED
OCT 16 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10382

CERTIFICATE OF DEATH

10372

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELICOTT CITY</i>		c. LENGTH OF STAY IN 1b <i>240</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>		d. STREET ADDRESS <i>413 N. Rose ST.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HIGHLAND MANOR CONV. HOME</i>				d. STREET ADDRESS <i>413 N. Rose ST.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CHRISTIAN</i>		First <i>J.</i>	Middle <i>Herold</i>	Last <i></i>	4. DATE OF DEATH <i>Oct.</i>	Month <i>23</i>	Day <i>1956</i>
S. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT. 3, 1867</i>		9. AGE (In years lost/birthday) <i>89 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TYPESETTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PRINTING</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Anthony</i>		14. MOTHER'S MAIDEN NAME <i></i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Marie SchAFCR 413 N. Rose ST.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i></i>		Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		(b) DUE TO <i></i>		Arterio Sclerotic Heart Disease			
(c) DUE TO <i></i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>10/4</i> , 1956, to <i>10/22</i> , 1956, that I last saw the deceased alive on <i>10/10</i> , 1956, and that death occurred at <i>M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Max J. Miller</i>						ADDRESS (Street, city or town, state) <i></i>	
PHYSICIAN'S NAME (Type) <i>MAX J. MILLER MD</i>						DATE SIGNED <i>5226 BACT. NAT. Office</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/26/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Rosary CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>BDABROWSKI 2818 E. BALTIMORE ST.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>25/1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. E. Loughran</i>	

STATE OF CALIFORNIA
CITY OF SACRAMENTO

URBAN Y.

11 25 1956

REVIEWED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10373

10383

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York		b. COUNTY Orange					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicot City		c. LENGTH OF STAY IN 1b 14 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walden		d. STREET ADDRESS 18 Riverview st.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaefers Conv. Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) AGNES		First RUSSELL	Middle JOCELYN	Last JOCELYN	4. DATE OF DEATH October	Month 24	Day 19	Year 56			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH March 18, 1875	9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Brooklyn, New York							
13. FATHER'S NAME ? Abracombrie		14. MOTHER'S MAIDEN NAME (unknown)									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Alden Jocelyn		203 Hammonds Ferry Rd Linthicum Heights, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b)		Acute Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 2 hrs					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c)				Arteriosclerotic Cardiovascular Disease		not known					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) COLUMBIA RD		(County) ELLIOTT CITY		(State) Md.	
21. I certify that I attended the deceased from 10-22 , 19 56 , to 10-24 , 19 56 , that I last saw the deceased alive on 10-22 , 19 56 , and that death occurred at 3:20 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Peter V. Thorpe M.D.										ADDRESS (Street, city or town, state) ELLIOTT CITY	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29/56		22c. NAME OF CEMETERY OR CREMATORIAL Cypress Hills Cem.		22d. LOCATION (City, town, or county) Brooklyn, New York				(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard Livingston		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR 10-29-1956		24b. REGISTRAR'S SIGNATURE J. E. Longhena					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

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THE ASSASSINATE OF DEWEY

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BUREAU V. S

OCT 29 1956

RECEIVED

10384

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:

COUNTY *Howard*

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(in this place)TOWN *Elkridge (Howard) 1956*HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

7220 Elm Ave

STREET ADDRESS

Elkridge 27 MD

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Annie Mariah Joy

4. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):10B. KIND OF BUSINESS
OR INDUSTRY:

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY.

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

6 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M. While Not while
at work at work 22. I hereby certify that I attended the deceased from *Sept 18 1956* to *Oct 16 1956* that I last saw the deceasedalive on *Oct 16 1956*, and that death occurred at *9 a.m.* from the causes and on the date stated above.SIGNATURE *John Brumbaugh*ADDRESS *3607 Maryland St 27 MD*DATE SIGNED *10/16/56*

23. BURIAL, CREMATION, DATE THEREOF

REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Oct 16, 1956

MRS. B. D. WILSON

W. CLARKE MALLING

LEONARD TAYLOR

BUREAU V. S.

OCT 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10375

10385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH-
CITY OR TOWN

Towson

MARYLAND

CITY (If outside corporate limits, write RURAL and
give nearest town)LENGTH OF STAY
(in this place)

TOWN

Elmridge

Maryland

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Maygreen

2. NAME OF
DECEASED
(Type or Print)

FRANK

JOSEPH

2. USUAL RESIDENCE (HOME) OF DECEASED-
CITY OR TOWN

COUNTY

Maryland

3. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

8. DATE OF BIRTH

9. AGE last birthday

June 16, '84

If under 1 year
Months Days

72 yrs.

If under 24 hrs.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

Shoe mender

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT
COUNTRY

USA

13. FATHER'S NAME

Jacob Petrik

14. MOTHER'S MAIDEN NAME

Kattura

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or date of
service)

16. SOCIAL SECURITY NO.

213-20-0685

17. INFORMANT AND ADDRESS

Ann M. Petrik

, Elmridge, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1. Immediate cause

(a) Prostate to live

INTERVAL BETWEEN
ONSET AND DEATH

3-4 months

Antecedent cause(s)

Disease or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) Carcinoma of prostate

3 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

(c) Extramammary pustular disease & cerebral

18 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg, etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURYINJURY OCCURRED
While at
WorkWhile at
Not While
At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

Nov. 1948, to Oct. 1956

, 1948, to Oct. 1956

alive on

Oct. 3, 1956

, 1956, and that death occurred at 11:20 P.M.

SIGNATURE

, from the causes and on the date stated above.

(Degree or title) ADDRESS

DATE SIGNED

Signature

Gavin P. Tuerling, M.D.

Riley 27, Md Oct 27, 1956

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORIAL
S. St. - u. justinesLOCATION (City, town, or county)
Edward S.O.I.d.

(State)

DATE REG'D BY LOCAL
REG.

10-10-56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS



10386 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

MARYLAND

LENGTH OF STAY
(In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

4. SEX:

5. COLOR OR
RACE:6. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify):

7. DATE OF BIRTH:

8. AGE last birthday

9. IF UNDER 1 YEAR

10. IF UNDER 24 HRS

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAR DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

219-09-0777

17. INFORMANT & ADDRESS:

9 Avenue I. Seminary, etc.

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN
ONSET AND DEATH

420.1

IMMEDIATE CAUSE

(A)
DUE TO

Angina pectoris leading to death.

ANTECEDENT CAUSE (S):

(B)
DUE TO

Cerebral hemorrhage

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

420.1

703.0

Cerebral hemorrhage

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

420.1

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES NO 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY: street, office bldg., etc.)21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

8

M. While Not while

Fall from bed

at work at work 22. I hereby certify that I attended the deceased from Jan 2, 1976, to Oct 6, 1976, that I last saw the deceased
alive on Dec 16, 1976, and that death occurred at 10:30 M, from the causes and on the date stated above.
SIGNATURE: *A. B. Brown*ADDRESS: *16139 2nd St. N.E., 17144*DATE SIGNED: *1/6/76*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial Oct 10, 1976

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

Glenview Cemetery, Dorsey, Howard Co., Md.

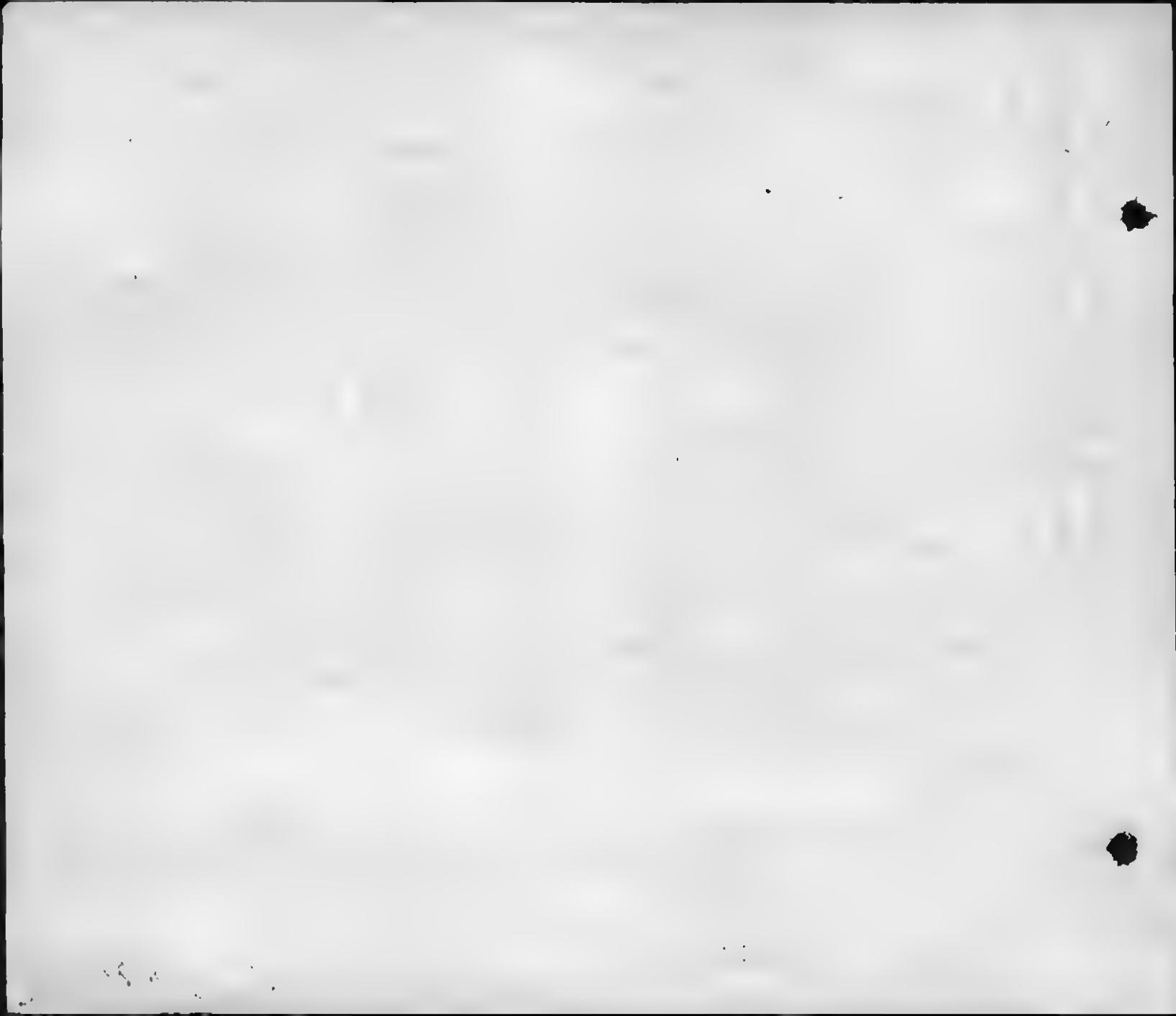
DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Oct 8, 1976

A. B. Henrich Henry W. Jenkins, Dorsey, Howard Co., York, Pa.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10377

10387

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>		d. STREET ADDRESS <i>526 N. Loudon Ave.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shaffer Convalescent Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First <i>Mary</i>	Middle <i>H.</i>	Last <i>Sewell</i>	4. DATE OF DEATH <i>October 2 1956</i>	Month <i>October</i>	Day <i>2</i>	Year <i>1956</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED <input checked="" type="checkbox"/></i>	8. DATE OF BIRTH <i>Nov. 26, 1888</i>	9. AGE (In years last birthday) <i>67 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>At home</i>		11. BIRTHPLACE (State or foreign country) <i>Richmond, Virginia</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Sidney Herndon</i>				14. MOTHER'S MAIDEN NAME <i>Frances Rives</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>-----</i>		17. INFORMANT <i>M. Edward Sewell-1764 Stanley Blvd.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial vascular accident</i>				Birmingham, Mich.		INTERVAL BETWEEN ONSET AND DEATH <i>0 days</i>		
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		(b) <i>Hypertension C/S disease</i>						
DUE TO <i>(c)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10377 Colver St. Baltimore 2 Md</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Jan. 1, 1956</i> to <i>Oct. 2, 1956</i> that I last saw the deceased alive on <i>Oct. 1, 1956</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>10377 Colver St. Baltimore 2 Md</i>		
ACTUAL SIGNATURE <i>John A. Kochman</i>						DATE SIGNED <i>10/5/56</i>		
PHYSICIAN'S NAME (Type) <i>Dr. J. A. Kochman</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/5/1956</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Riverview Cemetery</i>		22d. LOCATION (City, town, or county) <i>Richmond, Va.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		ADDRESS <i>4600 Liberty Hights. Ave.</i>		24a. REC'D BY REGISTRAR <i>10/5/56</i>		24b. REGISTRAR'S SIGNATURE <i>John A. Kochman</i>		

3 A CLOSER

STUDY

OF A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10378

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HOWARD.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE SAME		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL, MD.		c. LENGTH OF STAY IN 1b 11 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARDING RD		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) AMOS		First	Middle	Lost	4. DATE OF DEATH Oct	Month	Day	Year	
5. SEX MALE	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1890	9. AGE (In years lost, birthday) 66 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6	Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME GEORGE T SOUDER		14. MOTHER'S MAIDEN NAME MARY FRANCES MURPHY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-05-8844		17. INFORMANT LOIS SOUDER - WIFE - SAME ADDRESS		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO		MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 1 DAY.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO		ARTERIOSCLEROSIS		years			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		NONE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Hour a. m. p. m. 19		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Laurel	(County) Calvert	(State) MD
21. I certify that I attended the deceased from 10/12/56 , to 10/13/56 , that I last saw the deceased alive on 10/13/56 , and that death occurred at 2:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John R. Buell		M.D. 402 Main St. Laurel Md.		ADDRESS (Street, city or town, state) 10/13/56		DATE SIGNED 10/13/56			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORIAL Emmanuel Cem.		22d. LOCATION (City, town, or county) St. Croixville, Md.		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Randolph, Laurel Md.		ADDRESS 1913		24a. REC'D BY REGISTRAR D. H. Hedrick		24b. REGISTRAR'S SIGNATURE D. H. Hedrick			
VS AIS (4) ISM 9/55									

REAU V.

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10379

10389

CERTIFICATE OF DEATH

Reg. Dist. No.

197

1. PLACE OF DEATH a. COUNTY <i>Howard</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock</i>		c. LENGTH OF STAY IN 1b <i>20 years</i>		b. COUNTY <i>Howard</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock</i>		
			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First <i>Clara</i>	Middle <i>Belle</i>	Last <i>Stansfield</i>	4. DATE OF DEATH <i>October 29 1956</i>	Month <i>Oct.</i>	Day <i>29</i>	Year <i>1956</i>
5. SEX <i>ft.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Aug. 25, 1884</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	10c. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Millard R. Shiley</i>	14. MOTHER'S MAIDEN NAME <i>Frances Shiley</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Oscar Stansfield - Woodstock, Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, Culminating the heart disease,</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under (b) <i>Arteria, pylonychia, Cystitis</i> DUE TO (c) <i>Anuritis</i>				INTERVAL BETWEEN ONSET AND DEATH	

19. MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <i>1954</i> , 19, to <i>Oct 29 1956</i> , that I last saw the deceased alive on <i>29 Oct 1956</i> , and that death occurred at <i>2:20 PM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i>	DATE SIGNED <i>Howard E. Hall M.D. 29 Oct 1956</i>
ACTUAL SIGNATURE <i>Howard E. Hall M.D.</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
PHYSICIAN'S NAME (Type) <i>HORACE E. HALL</i>	22b. DATE THEREOF <i>10-31-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bethel N. Haight - Sykesville, Md.</i>	22d. LOCATION (City, town, or county) <i>Howard Co., Md.</i>	(State)

24a. REC'D BY REGISTRAR <i>V 7 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Mrs. Alice Debby</i>
VS A15 (4) ISM 9/55	

BUREAU V. S.

NOV 7 1926

KEEV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the physician may be rejoined by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the physician. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10390

CERTIFICATE OF DEATH

10380

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cooksville</i>		b. COUNTY <i>Howard</i>	
c. LENGTH OF STAY IN 1b <i>70 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cooksville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i>Route # 144</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>EFFIE</i>		First <i>Marie</i>	Middle <i>Thomas</i>
4. DATE OF DEATH <i>October 25</i>		Month <i>Oct</i>	Day <i>25</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 15, 1884</i>		9. AGE (in years from birthday) <i>72 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Howard Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James A. Bond</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>John A. Thomas - Cooksville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO <i>Cardiac arrest, Coronary Thrombosis</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension, Cerebral vascular</i>		DUE TO (c) <i>accident (at side)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 19 <i>54</i> , to <i>Oct. 25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Oct. 25</i> , 19 <i>56</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Cooksville, Md.</i> DATE SIGNED <i>10-26-56</i>	
ACTUAL SIGNATURE <i>Howard E. Hall</i>		PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-28-56</i>	
22c. NAME OF CEMETERY OR Crematory <i>Bushy Park</i>		22d. LOCATION (City, town, or county) <i>Cooksville, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight - Cooksville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>10-26-56</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i>C. Cherry Weir</i>	

DUPEAU A. S.

OCT 99 1996

DEPARTMENT OF
EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10381

10391

CERTIFICATE OF DEATH

Reg. Dist. No.

192

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mariottsville</i>		c. LENGTH OF STAY IN 1b <i>50 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mariottsville</i>	
3. NAME OF DECEASED (Type or print) <i>HARRY</i>		First <i>H</i>	Middle <i>W</i>
4. DATE OF DEATH <i>October 31 1956</i>		Last <i>W</i>	Month <i>Oct</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 22 1871</i>
9. AGE (In years last birthday <i>85 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Unk -</i>	12. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Sullivan</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Unk</i>	17. INFORMANT <i>McGeorge B. Hayes - Mariottsville, Md</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 24, 1956</i> , to <i>Oct 31, 1956</i> , that I last saw the deceased alive on <i>Oct 30, 1956</i> , and that death occurred at <i>3 A. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. E. Martin</i>		ADDRESS (Street, city or town, state) <i>Randallstown, Md</i>	
PHYSICIAN'S NAME (Type) <i>Wm. E. MARTIN</i>		DATE SIGNED <i>11/15/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-2-56</i>	22c. NAME OF CEMETERY OR CEMMATORY <i>Springfield</i>
22d. LOCATION (City, town, or county) <i>Odenton, Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Haight - Atyleville, Md</i>		24a. REG'D BY REGISTRAR <i>NOV 7 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Alice Kelly</i>

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU OF INVESTIGATION
NOV 7 1956
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10382

10392

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Highland Mans</i>		d. STREET ADDRESS <i>13 Mallow Hill Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Henry</i>	Middle <i>F.</i>	Last <i>Wiesner</i>
4. DATE OF DEATH	Month <i>10/23/56</i>	Day <i>19</i>	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/16/1872</i>
9. AGE (In years last birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS. Days <i>1</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
14. FATHER'S NAME <i>John Wiesner</i>	15. MOTHER'S MAIDEN NAME <i>Greenglass</i>		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	17. SOCIAL SECURITY NO. <i>420.0</i>	18. INFORMANT <i>Edwin P. Wiesner, Jr.</i>	19. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		20. HYPOVENTILATION Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Cardiac Failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>8/10, 1956 to</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/16, 1956</i> , and that death occurred at <i>8/10, 1956</i> , that I last saw the deceased alive on <i>10/16, 1956</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5228 Balt Natl Blk</i>	DATE SIGNED <i>10/25/56</i>		
ACTUAL SIGNATURE <i>Max J Miller</i>	M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/26/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Lorraine</i>
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Miller-1207, 28</i>		24a. REC'D BY REGISTRAR <i>OCT 29 1956</i>	24b. REGISTRAR'S SIGNATURE <i>J. E. Laughren</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HOMELAND SECURITY
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DELIVERY

BUREAU V. S.

OCT 29 1956

RECEIVED